State of California-Health and Human Services Agency
Department of Health Services

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Director

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Governor

Home- and Community-Based Services (HCBS) Waiver Application

⇒ *Para recibir esta información en español, por favór llámenos a uno de los números siguientes: (916) 552-9105.*

To apply for one of the Medi-Cal HCBS Waivers administered by the In-Home Operations (IHO) Section, please complete this two-page application.

Applicant's Name: _____ **Home Phone:** (____) _____

Date of Birth: _____ **Age:** _____ **Married:** ☐ Yes ☐ No

Mailing Address:_____ **City:** _____, **CA ZIP:** _____

Street Address:_____ **City:** _____, **CA ZIP:** _____
(If different from Mailing Address)

Health Care Insurance:

Medi-Cal? ☐ Yes ☐ No If yes, Medi-Cal Number _____
Located on the applicant's Medi-Cal Beneficiary Identification Card (BIC)

Medicare? ☐ Yes ☐ No If yes, ☐ Part A ☐ Part B ☐ Part A & B ☐ Part D

Other Medical Insurance? ☐ Yes ☐ No If yes, identify _____

List current medical diagnoses (main illness or injury): _____

_____

_____

Check the boxes that identify your current medical needs. Use the blank spaces below to write-in your specific medical needs that are not listed. You may provide additional comments on the back of the application.

☐ Ventilator - Hours Used Per Day (hrs/day) _____
☐ Continuous Positive Airway Pressure (CPAP) Device – hrs/day _____
☐ Bi-Level Positive Airway Pressure (BiPAP) Device – hrs/day _____
☐ Respiratory Treatments - number per day _____
☐ Room Air Mist
☐ Oral (by mouth) Medications
☐ Gastric Tube (GT) Medications
☐ Intravenous (IV) Medications
☐ Chronic Pain Treatment
☐ Contractures
☐ Continuous Use of Oxygen
☐ Oral (by mouth) Feedings
☐ Gastric Tube (GT) Feedings
☐ Intravenous (IV) Nutrition
☐ Pressure Sores/Open Wounds
☐ Skin or Wound Treatments
☐ Tracheostomy
☐ Tracheal Suctioning
☐ Oral Suctioning
☐ Nasal Suctioning
☐ Oxygen as needed
☐ Urinary Incontinence
☐ Bladder Catheterizations
☐ Bowel Incontinence
☐ Routine Bowel Care
☐ Urostomy/Colostomy
☐ Some ability to move arms or legs. Needs some help with care needs. Briefly explain on back.
☐ No movement of arms or legs. Needs total help with care needs. Briefly explain on back.
☐ Special equipment needs. (ex: wheelchair, lift system, ramp) Briefly explain on back.
☐ Other_____

HCBS Waiver Application, *continued*

If this application is being submitted <u>for</u> the applicant:

1. Was he/she or the legal representative notified of this application for the HCBS Waiver? ☐ Yes ☐ No
2. Who has the legal authority to make the applicant's health care decisions?

   ☐ Applicant ☐ Other: _____ _____ (____) _____
   Name Relationship Telephone Number
3. Where is the applicant currently residing?

   ☐ At home ☐ Hospital ☐ Nursing facility: _____
   Facility Name and City

   ☐ Other: _____
   Please specify

Please identify all of your current providers of service:

☐ **Home Health Agency** – Name: _____ Hours per week: _____
Type of services received: ☐ Attendant Care ☐ Certified Home Health Aide (CHHA)
☐ Nursing: RN ___ LVN___

☐ **In-Home Supportive Services (IHSS)** - Hours Authorized Per Month: _____

- *To obtain IHSS eligibility information, please contact the applicant's county Department of Social Services office and ask for the IHSS Intake Department.*

☐ **California Children Services (CCS)** - Please describe the service(s) and frequency received:
Service: _____ Frequency: _____
Service: _____ Frequency: _____

☐ **Regional Center** _____ Service Coordinator: _____
Center Name Name

☐ **Adult or Pediatric Day Health Care**: _____ Days per week: _____
Center Name

☐ **Attends school outside of the home?** If yes, # days/week? _____ # hours/day? _____
Does the school provide medical care services at school? (Ex; nursing care, therapy) ☐ Yes ☐ No

☐ **Multipurpose Senior Services Program (MSSP)**

- *MSSP is an HCBS waiver benefit for Medi-Cal beneficiaries over the age of 65 that provides general services and nursing support. For further information on this program, please call 1-800-510-2020, or go to www.aging.state.ca.us/html/programs/mssp*

☐ **Hospice**

- *Hospice is a Medicare/Medi-Cal benefit for beneficiaries with a terminal diagnosis. For further information on this benefit, contact the applicant's physician.*

☐ **Medical Case Management (MCM)**

- *MCM offers short-term medical care services for beneficiaries without other sources of health insurance. For further information, please call (916) 552-9100.*

Please return the completed application to IHO at the address listed below. Should you (the applicant) relocate, have a significant change in your/his/her health care needs, or change your/his/her Medi-Cal insurance status, please contact IHO at (916) 552-9105.

_____ (____) _____ _____
Print name and title of person completing the application **Contact Telephone** **Date**

Enclosures